A Guide to

Health Insurance

and

Worker's Compensation

Insurance

for Farm Families

State of Wisconsin
Office of the Commissioner of Insurance
P.O. Box 7873
Madison, WI 53707-7873

OCI's World Wide Web Home Page:
http://oci.wi.gov

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The mission of the Office of the Commissioner of Insurance . . .

Leading the way in informing and protecting the public

and responding to their insurance needs.

If you have a specific complaint about your insurance, refer it first to the insurance company or agent involved. If you do not receive satisfactory answers, contact the Office of the Commissioner of Insurance (OCI).

For information on how to file insurance complaints call:

(608) 266-0103 (In Madison)
or
1-800-236-8517 (Statewide)

Mailing Address
Office of the Commissioner of Insurance
P.O. Box 7873
Madison, WI 53707-7873

Electronic Mail
information@oci.state.wi.us
(please indicate your name, phone number, and e-mail address)

OCI's World Wide Web Home Page
http://oci.wi.gov

For your convenience, a copy of OCI's complaint form is available at the back of this booklet. A copy of OCI's complaint form is also available on OCI's Web site. You can print it, complete it, and return it to the above mailing address.

A list of OCI's publications is included at the back of this booklet. Copies of OCI publications are also available on-line on OCI's Web site.

Deaf, hearing, or speech impaired callers may reach OCI through WI TRS

Disclaimer

This guide is not a legal analysis of your rights under any insurance policy or government program. Your insurance policy, program rules, Wisconsin law, federal law and court decisions establish your rights. You may want to consult an attorney for legal guidance about your specific rights.

The OCI does not represent that the information is complete, accurate or timely in all instances. All information is subject to change on a regular basis, without notice.

Printed copies of publications are updated annually unless otherwise stated. In an effort to provide more current information, publications available on OCI's Web site are updated more frequently to reflect any necessary changes. Visit OCI's Web site at http://oci.wi.gov.

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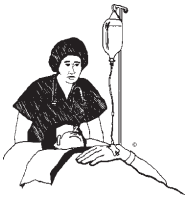
Small Employer Web Site

The Office of the Commissioner of Insurance (OCI) developed a Web site to help small employers become more knowledgeable insurance consumers. The Insurance Coverage for Small Employers Web page (http://oci.wi.gov/smempins.htm) assists Wisconsin small employers by providing information on the different types of insurance policies on the market, how much coverage to buy, and how to buy it wisely.

Farm owners need health insurance to cover medical expenses for themselves and their families. As employers, farmers may also provide standard health insurance and worker's compensation insurance to employees. This booklet describes both health insurance and worker's compensation insurance.

Health Insurance



Health insurance generally provides payment for medical treatment and/or hospital stays. It often is available on a group basis through an employer, union, or association. In other cases people buy individual policies.

Group health insurance. Group health insurance is frequently available if a farmer is an employer, an employee, or the dependent of an insured person. Group health insurance provides coverage to individuals under a single master policy issued to the group policy owner. Certificates of insurance are provided to the individuals. The policy owner may be an employer, an association, a labor union, or other entity. Unless the group is small, no individual medical underwriting is performed. Instead, insurers require minimum employee or member participation levels and minimum employer contribution levels in order to assure that there are sufficient individuals in the group in good health to balance those in the group in poor health.

Group health insurance provides several advantages:

- The premium is often partly paid by an employer or union;
- The ratio of total benefits paid to total premiums received is usually quite high;
- You are automatically eligible if you are a group member, and there may or may not be additional screening for medical problems.
- Group premiums are typically lower than those for comparable individual policy coverage.

Trust Groups. Farmers, as farm owners or employers, also have the option of enrolling in farm insurance association/trust groups, which are offered through the Farm Bureau Association or your local dairy cooperative. These trust groups provide coverage for a **pool** of employers. Such plans may offer comprehensive major medical coverage. Farms which are subsidiaries or affiliates of employers participating in the trust and employees of such subsidiaries or affiliates can also be eligible under the trust policy. Have your agent explain any waiting periods, limitations, and exclusions that might apply.

Individual health insurance. Farmers not qualifying for group health insurance may want to buy individual health coverage. Individual health insurance provides coverage to a specific individual or to an individual and their family under a policy issued to that individual. In order to be considered for individual health insurance coverage, you will be asked to provide evidence of insurability that may require you to undergo a medical examination. This is called medical underwriting. The same requirements would apply to any dependents you may insure under the policy. Medical underwriting is discussed further on page 13.

Finding adequate coverage at an affordable price will take some effort. Start with a knowledgeable health insurance agent who will provide reliable service. Try to get a recommendation from family or friends. Otherwise check the yellow pages of the telephone book. If you are turned down by one company, try another. Insurers have different standards.

A. Choosing a Plan

Choosing a health insurance plan is like making any other major purchase. You choose the plan that meets both your needs and your budget. For most people, this means deciding which plan is worth the cost. Plans differ, both in how much you have to pay and how easy it is to get the services you need.

Health insurance plans are usually described as a fee-for-service health plan or a managed care health plan. A fee-for-service health plan allows you to use any doctor, hospital, or other provider you choose. Although these plans offer the greatest freedom to select any doctor, they are usually more expensive than plans that limit choices. Managed care health plans usually cost you less, but you give less freedom of choice.

Cost isn't the only thing to consider when buying health insurance. You also need to consider what benefits are covered. You need to compare plans carefully for both cost and coverage.

While fee-for-service and defined network plans differ in important ways, in some ways they are similar. A defined network plan is the term used in Wisconsin insurance law to refer to any health benefit plan that creates incentives for its enrollees to use network

providers. See page 6 for more information about defined network plans. Both cover an array of medical, surgical, and hospital expenses. Most offer some coverage for prescription drugs; and some include coverage for dentists and other providers. But there are many important differences that will make one or the other form of coverage the right one for you.

Fee-for Service Health Plan

Under a fee-for-service health plan, you are free to seek necessary medical care from any doctor and hospital you wish. The doctor often bills the insurance company directly for the services provided, and the insurance company pays for the items covered by the policy. In some cases you will have to fill out claim forms and send them to the insurance company. This type of health plan offers the most choices of doctors and hospitals.

Features of a Fee-for-Service Health Plan

The following section discusses how a fee-for-service health plan works.

Deductible

In some plans, you have to meet a deductible. The deductible is the dollar amount that you must pay each year before the insurance company pays its share. The deductible may range from $100 to $300 per year per individual or $500 or more per family. For example, if you have a $500 annual deductible, you will pay for the first $500 of covered expenses for each person insured.

If you are buying coverage for your family, ask how the family plan works. Some plans may not require each family member to pay the deductible after two people in the family have paid it.

Read the policy carefully. Some policies require you to pay a deductible on a calendar year basis or on a per sickness or injury basis.

Coinsurance

Coinsurance is your share or the percentage of covered expenses you must pay in addition to the deductible. The most common coinsurance arrangement is for the insurance company to pay 80% and you pay 20% as coinsurance until a maximum out-of-pocket expense is reached. Coinsurance applies to each person and starts over again each year. Sometimes the policy will cover all expenses after a certain point. Look at the list of covered expenses for the policy to see how comprehensive it is.

Out-of-Pocket Limit

Many plans have an out-of-pocket limit. The out-of-pocket limit is the maximum dollar amount that you pay for covered services and supplies during a specified period, generally a calendar year. The maximum may be defined to include or exclude the deductible. Once the out-of-pocket maximum is paid, benefits are paid at 100% of the costs incurred after that time.

Lifetime Maximum

Your major medical policy puts a cap, such as $1 million, on the total amount the policy will pay toward your medical expenses. When the company has paid that amount, the policy will be “used up” and no more benefits will be paid for your medical expenses. If you expect to have significant medical expenses, make sure to check the plan’s lifetime maximum.

Medically Necessary

Every major medical policy contains a provision that allows insurance companies to evaluate whether a service or treatment is “medically necessary” in treating a patient and whether it could adversely affect the patient’s condition if it were omitted. Insurance companies can deny payment for a treatment that is not medically necessary. Most health benefit plans often require a review before certain medical procedures are done.

Usual, Customary, and Reasonable Charge

Most insurance companies do not use your actual bills to calculate their payments. Companies have their own fee schedule, often known as usual, customary, and reasonable (UCR) charges. The UCR charges are typical amounts paid for everything from a doctor’s visit to heart surgery.

For example if your doctor charges $1,000 for an operation while most doctors in your area charge only $800, you will be billed for the $200 difference. This is in addition to the deductible and coinsurance you would be expected to pay. To avoid this additional cost, ask your doctor to accept your insurance company’s payment as full payment, or shop around to find a doctor who will. Otherwise, you will have to pay the difference.

Exclusions and Limitations

There are some services that plans won’t cover—usually because they are not considered medically necessary. In addition, some services, such as mental health and substance abuse treatment, may be limited. Review each plan’s exclusions and limitations. Keep in

mind that you have to pay the full cost of care that isn't covered.

Defined Network/Managed Care Health Plan

A defined network plan is the term used in Wisconsin insurance law to refer to any health benefit plan that creates incentives for its enrollees to use network providers. Some defined network plans will provide coverage only if the enrollee uses network providers and other plans will pay a larger portion of the charges if the enrollee uses network providers. HMOs, point-of-service plans and preferred provider plans are examples of defined network plans. This type of plan is sometimes referred to as a managed care plan.

Health Maintenance Organization (HMO)

An HMO is a health insurance plan that provides comprehensive, prepaid medical care. It differs from a traditional insurer in that it both pays for and provides the medical care. Persons insured by an HMO plan are referred to as enrollees. An HMO usually operates on a closed panel basis. This means the enrollees are required to seek care from a medical provider who is either employed by or under contract to the HMO.

Except for serious emergencies or the need for urgent care outside the service areas, the HMO will probably not pay for care enrollees receive from a provider who is not affiliated with the HMO unless the HMO physician refers you to that provider.

Point-of-Service Plan (POS)

POS plans are essentially HMOs that allow members to use services provided outside of the network without prior approval from a network doctor. POS plans offer lower deductibles and no coinsurance for visits to doctors inside the network. Visits outside the network normally require the payment of deductibles and coinsurance the same as a standard insurance policy.

Preferred Provider Plan

A preferred provider plan (PPP) is marketed by an insurer to several employers. Providers have agreed to provide care on a reduced fee-for-service basis. The PPP also gives incentives to insureds to use preferred providers. For example, the plan may have a copayment provision in which the insurer pays 80% and the insured pays 20%. However, if insureds use the preferred providers, the insurer pays 90% rather than 80% of covered expenses.

Many insurers that offer standard health insurance policies also offer some type of preferred provider plan. You should ask your agent to provide you with information on preferred provider plans in your area.

Features of a Defined Network Health Plan

The following section discusses how a defined network health plan works.

Provider Directories

All defined network plans will provide an enrollee with a provider directory listing hospitals, primary care physicians, and specialty providers from whom the enrollee may obtain services. These directories are updated annually. However, the enrollee should inquire at the time of making an appointment as to whether the provider is currently a member of the defined network organization.

Continuity of Care

If a defined network plan represented a primary care physician (defined as a physician specializing in internal medicine, pediatrics, or family practice) as being available during an open enrollment period, it must make the physician available at no additional cost for the entire plan year. A specialist provider must be made available for the lesser of the course of treatment or 90 days. If an enrollee is in her second trimester of pregnancy, the provider must be available through postpartum care. The exceptions are for a provider who is no longer practicing in the defined network plan's service area or who was terminated from the plan for misconduct.

Referral Procedure

Some HMOs require a referral from a primary care physician before an enrollee can see another plan provider. All HMOs require the enrollee to have a referral that has been approved by the plan before going to a non-plan provider. The certificate booklet includes information on the procedure to follow and any notification requirements.

A defined network plan may not require a referral from a physician for services from a plan chiropractor. It must also allow a woman to receive obstetrical and gynecological services from a plan physician who specializes in obstetrics or gynecology without requiring a referral from her primary care provider.

Defined network plans must have a procedure allowing for standing referrals. A standing referral authorizes an enrollee to be seen by a specialist provider for a specific duration of time or specific number of visits

without having to obtain a separate referral from the primary provider for each visit to the specialist.

If an enrollee goes to a non-HMO provider without an approved referral, the claim for those services will not be reimbursed by the HMO. Enrollees have the right to file a grievance when a referral is denied.

Second Opinions

Every defined network plan must cover a second opinion from another provider within the defined network plan provider network.

Disenrollment

An HMO must disclose in the policy and certificate any circumstances under which an enrollee may be disenrolled. Disenrollment proceedings may be initiated only for the following reasons:

- The enrollee has failed to pay required premiums by the end of the grace period.
- The enrollee has committed acts of physical or verbal abuse, which pose a threat to providers or other members of the organization.
- The enrollee has allowed a nonmember to use the HMO's certification card to obtain services or has knowingly provided fraudulent information in applying for coverage.
- The enrollee has moved outside of the geographical service area of the organization.
- The enrollee is unable to establish or maintain a satisfactory physician-patient relationship with the physician responsible for the enrollee's care.

Enrollees have the right to file a grievance when a disenrollment proceeding is initiated.

Small employer health insurance is available in Wisconsin from several insurers and defined network plans. The OCI publishes a brochure that is meant to help small employers understand their options and to provide a comparison of premium rates available in the small health insurance marketplace. To obtain a copy, contact the OCI at 1-800-236-8517 and ask for a copy of *Health Insurance for Small Employers and Their Employees.* A copy is also available on OCI's Web site at http://oci.wi.gov/pub_list/pi-206.htm.

B. Finding the Right Coverage

Before you can begin to shop and compare health insurance policies, you should become familiar with the terms of a health insurance policy.

- Out-of-pocket expenses. Know the policy's deductibles, copayments, and maximum annual and lifetime payouts. Ask if there are different out-of-pocket expenses for different kinds of care, such as mental health.
- Request a complete explanation of the policy's provisions for preexisting conditions or waivers of coverage for specific medical conditions. Find out exactly what coverage you have for illnesses you had before you bought the policy.
- Ask about renewability. A guaranteed renewable policy protects you from cancellation or nonrenewal of the policy because of too many claims. Insurers may raise premiums on these policies.
- The fine print. Be aware of the circumstances under which a policy will and will not cover some services. Ask specifically about limitations and exclusions on experimental procedures, transplants, infertility treatments, drug therapies, and durable medical equipment.
- Check on whether the policy covers actual or reasonable expenses or if benefits are limited to a scheduled dollar amount. There can be quite a gap between actual and either reasonable or scheduled expenses. Is the insurance company's schedule of "allowable charges" realistic in light of what local providers actually charge?
- How much paperwork? If you are joining an HMO, the paperwork will be pretty minimal. But PPOs and traditional indemnity plans may require you to file claim forms for reimbursement. How quick is the turnaround time for claims and appeals?

When shopping for health insurance coverage, consider your health insurance needs. A bare-bones policy may not be for you. It might be wise to spend your health care dollars on one comprehensive major medical policy. Extra policies probably aren't necessary. If you need more coverage, some health plans allow you to add benefits. If one policy costs less than another, it usually provides fewer benefits; may be too limited to be your sole health care coverage; and may duplicate coverage you already have.

In the case of individual HMO and individual coverage, state law requires a 10-day "free look." You can change your mind and receive a refund if you return the individual policy within the free-look period. That period starts when you receive the policy. If you return the policy, send it by certified mail, return receipt requested. That gives you a record of the return date in case a dispute arises. State law does not require a free-look period for group insurance or group HMO coverage.

C. How to File a Health Insurance Claim

Things to do Before Filing a Claim

Read your benefit booklet carefully before you have a claim. Understand what is and is not covered. Follow all procedures and deadlines for seeking treatment and filing complaints and appeals. The majority of insurance companies maintain a toll-free telephone information and complaint line, and some companies and HMOs provide special mediation or arbitration procedures for handling complaints.

Filing Your Claim

- It is important to find out if your provider submits the claim for you or if you need to do it. If you are insured through an HMO, you will rarely, if ever, see the actual bill for your health care services. Insurance companies pay claims for fee-for services differently.
- If you need to file the claim, review the information to be sure it is complete and correct.
- File it as soon as you get the bill from the provider.
- Send it to the right address.
- Keep a copy for your reference.

Processing Your Health Claim

Allow a reasonable time for the company to process your claim. The company will inform you if it needs any additional information to complete the claim. The company may also request more information from the provider or return the claim form to you to get more information.

Once the insurance company receives the claim form, it reviews the claim and tells the provider what it will pay for the services. The insurance company also sends you, the insured, a form known as an "EOB" (explanation of benefits) that tells you the same thing about your claim.

It is very important for you to look at your EOBs and any doctors' bills you get. You should make sure the services listed on an EOB match the services you received. If a service is not covered, or is only partially covered (if, for example, you have to pay a 20% coinsurance), the EOB will help you understand what you will be billed by the doctor or hospital after the insurance company pays its share.

How the Claim is Paid

If you assigned benefits to the provider, the benefit check will be sent directly to the provider.

You will pay any deductibles and coinsurance.

If you did not assign the benefits, the check will come to you and you will need to pay your providers for the entire amount.

If Your Claim is Denied

All health insurance plans, including all defined network plans are required to have an internal grievance procedure for those who are not satisfied with the service they receive. The procedure must be set forth in the insurance contract and must also be provided in written notice.

The defined network plan must provide each enrollee with complete and understandable information about how to use the grievance procedure. An enrollee has the right to appear in person before the grievance committee and present additional information.

If you are not satisfied with the outcome of the grievance, you have an additional way to resolve some disputes involving medical decisions. You or your authorized representative may request that an Independent Review Organization (IRO) review your health plan's decision.

In most cases, you will need to complete your health plan's internal grievance procedure. After you receive the insurer's final decision on your grievance, choose an IRO from the list provided by the insurer. Then send a written request for independent review to the insurance company.

Your health plan should provide you with information on your right to request an independent review in its written materials. You can also call the health plan at its toll-free number and request information on independent review.

For more information on the independent review process, call the OCI and request a copy of *Fact Sheet on the Independent Review Process in Wisconsin*. A copy is also available on the OCI's Web site at http://oci.wi.gov/pub_list/pi-203.htm.

If you do not resolve the matter, file a formal complaint with the OCI. For your convenience, a complaint form (http://oci.wi.gov/com_form.htm) is included in the back of this booklet.

Other Insurance Options

Health Insurance Risk-Sharing Plan (HIRSP)
(http://www.dhfs.state.wi.us/hirsp/index.htm)

HIRSP was created in 1979 for Wisconsin residents. The plan makes health insurance available to people who either are unable to find adequate health insurance coverage in the private market due to their medical conditions or who have lost their employer-sponsored group health insurance. Two plans are available to eligible persons under the HIRSP major medical policy. For more information about HIRSP, including eligibility, covered services, and policy options write or call HIRSP, 6406 Bridge Rd., Ste. 18, Madison, WI 53784-0018, (800) 828-4777 or (608) 221-4551.

BadgerCare
(http://www.dhfs.state.wi.us/badgercare/index.htm)

BadgerCare is Wisconsin's program to provide health insurance for uninsured families.

To be eligible, you must meet all of the following criteria:

- You must have children under age 19 living with you.
- Your income must be within the guideline limits.
- There is no limit on assets.
- You must not be covered by health insurance.

BadgerCare provides a comprehensive health benefit package. Premiums are generally zero if your family income is less than 150% of the federal poverty level, but in no event will premiums exceed 3% of your family income.

If you would like more information about BadgerCare, contact your county Human or Social Services Department or Certifying Tribal Agency (http://www.dhfs.state.wi.us/Medicaid1/contacts/medcontact2.htm) or local WW-2 office or call 1-800-362-3002 (TTY and translation services available).

Requirements Applicable to All Health Benefit Plans

Emergency Care

Every health plan offered in Wisconsin that covers emergency care, including defined network plans, must cover services required to stabilize a condition that most people would consider to be an emergency, without prior authorization. Defined network plans are permitted to charge a reasonable copayment or coinsurance for this benefit.

Grievance Procedure

All health insurance plans, including all defined network plans are required to have an internal grievance procedure for those who are not satisfied with the service they receive. The procedure must be set forth in the insurance contract and must also be provided in written notice.

The defined network plan must provide each enrollee with complete and understandable information about how to use the grievance procedure. An enrollee has the right to appear in person before the grievance committee and present additional information.

Enrollees may wish to first contact the defined network plan with a question or complaint. Many complaints can be resolved quickly and require no further action. However, filing a complaint with the plan first is not required. An enrollee can file a complaint with the appropriate state agency instead of, before, or at the same time as filing with the defined network plan.

Defined network plans are required to have a separate expedited grievance procedure for situations where the medical condition requires immediate medical attention. The procedure requires defined network organizations to resolve an expedited grievance within 72 hours after receiving the grievance.

Defined network plans are required to file a report with the OCI listing the number of grievances they had in the previous year. A summary of this information for HMOs is included in *The Consumer's Guide to Managed Care Plans in Wisconsin*. To receive a copy of this brochure call the OCI at 1-800-236-8517. A copy is available on the OCI's Web site at http://oci.wi.gov/pub_list/pi-044.htm.

Independent Review

All insurance companies offering health benefit plans in Wisconsin are required to have an internal grievance process to resolve any complaint you may have with the plan. If you are not satisfied with the outcome of the grievance, you have an additional way to resolve some disputes involving medical decisions. You or your authorized representative may request that an Independent Review Organization (IRO) review your health plan's decision.

The independent review process provides you with an opportunity to have medical professionals who have no connection to your health plan review your dispute. You choose the IRO from a list of review organizations certified by the OCI. The IRO assigns your dispute to a clinical peer reviewer who is an expert in the treatment of your medical condition. The IRO has the authority to determine whether the treatment should be covered by your health plan.

The independent reviews are conducted by IROs that are certified by the OCI. In order to be certified the IRO must demonstrate that it is unbiased and that it has procedures to ensure that its clinical peer reviewers are qualified and independent.

In most cases, you will need to complete your health plan's internal grievance procedure. After you receive the insurer's final decision on your grievance, choose an IRO from the list provided by the insurer. Then send a written request for independent review to the insurance company.

Your health plan should provide you with information on your right to request an independent review in its written materials. You can also call the health plan at its toll-free number and request information on independent review.

For more information on the independent review process, call the OCI at 1-800-236-8517 and request a copy of *Fact Sheet on the Independent Review Process in Wisconsin*. A copy is also available on the OCI's Web site at http://oci.wi.gov/pub_list/pi-203.htm.

Mandated Benefits

Health insurance policies sold in Wisconsin often include "mandated benefits." These are benefits that an insurer must include in certain types of health insurance policies. Except for HMOs organized as cooperatives under ch. 185, Wis. Stat., HMOs are required to provide the same benefits as traditional insurers. Cooperative HMOs are subject to the mandates regarding chiropractors, optometrists, genetic testing, nurse practitioners, newborns, adopted children, HIV drugs, dentists, temporomandibular (TMJ) disorders, breast reconstruction, and hospital and ambulatory surgery center charges and anesthetics for dental care.

The mandated benefits required by Wisconsin state law include coverage for: professional health care services; adopted children; handicapped children; nervous and mental disorders, alcoholism, and other drug abuse; home health care; skilled nursing home care; kidney disease; mammography; new born infants; coverage for grandchildren born to dependent children under the age of 18 who are covered by the policy; diabetes, lead screening, and maternity coverage for all persons covered under the policy if it provides maternity coverage for anyone, genetic testing, drugs for treatment of HIV infection, TMJ disorders, hospital and ambulatory surgery center charges and anesthetics for dental care, and breast reconstruction.

Insurer plans must provide at the least the minimum mandated coverage but may provide benefits that are greater than those mandated by law. Some mandated benefits apply only to group policies. Some apply both to policies sold to individuals and to groups. For more information on mandated benefits, call the OCI at 1-800-236-8517 and request a copy of *Fact Sheet on Mandated Benefits in Health Insurance Policies* (http://oci.wi.gov/pub_list/pi-019.htm).

The Health Insurance Portability and Accountability Act of 1996

Federal and state laws provide important consumer protections for those who have preexisting medical conditions and move from one job to another. Legislation passed during the 1997 legislative session brings Wisconsin insurance laws into compliance with the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA). HIPAA does not mandate that employers provide insurance. It does not require insurance plans to cover specific services (except in some limited situations) or regulate the premiums that may be charged by insurers. In general, most of the new laws cover group health plans only. Very few changes were made to individual health plans.

The OCI publishes a brochure designed to provide a general overview to the federal law as well as the changes made to state health insurance law. You may request a copy of *The Health insurance Portability and Accountability Act of 1996 and 1997 Wisconsin Act 27* (http:// oci.wi.gov/pub_list/pi-096.htm) by calling the OCI at 1-800-236-8517.

Continuation and Conversion

Both state and federal law give certain individuals who would otherwise lose their group health care coverage under an employer or association plan, the right to continue their coverage for a period of time. The two laws are similar in some ways, but also have provisions that are very different. Most employers that have 20 or more employees must comply with the federal law, while most group health insurance policies that provide coverage to Wisconsin residents must comply with the state law. When both laws apply to the group coverage, it is the opinion of the Office of the Commissioner of Insurance that where the federal and state laws differ, the law most favorable to the insured should apply. The state law also gives conversion rights to certain individuals who are covered under individual health insurance policies.

Federal Law (COBRA)

The Consolidated Omnibus Budget Reconciliation Act (COBRA) is a federal law that allows most employees, spouses, and their dependents who lose their health coverage under an employer's group health plan to continue coverage, at their own expense, for a period of time. This law applies to both insured health plans and self-funded employer-sponsored plans in the private sector and those plans sponsored by state and local governments. However, COBRA does not apply to certain church plans, plans covering less than 20 employees, and plans covering federal employees.

Under the federal law, employees who terminate employment for any reason other than gross misconduct, or who lose their eligibility for group coverage because of a reduction in work hours, and the covered spouses and dependents of the employees may continue the group coverage for up to 18 months. A spouse and dependents may continue coverage for up to 36 months if they lose coverage due to the death of the employee, divorce from the employee, loss of dependent status due to age, or due to the employee's eligibility for Medicare. If within the first 60 days of COBRA coverage an individual or dependent is determined to be disabled by Social Security, the disabled individual and other covered family members may continue coverage for up to 29 months.

Wisconsin Law (s. 632.897, Wis. Stat.)

Wisconsin's continuation law applies to most group health insurance policies that provide hospital or medical coverage to Wisconsin residents. The law applies to group policies issued to employers of any size. The law does not apply to employer self-funded health plans, or policies that cover only specified diseases or accidental injuries.

Where to go for Help

For questions about the Wisconsin continuation law, contact:

Office of the Commissioner of Insurance
P.O. Box 7873
Madison, WI 53707-7873
(608) 266-0103 (In Madison)
1-800-236-8517 (Outside Madison)
http://oci.wi.gov

For questions about the federal COBRA law, contact:

U.S. Department of Labor - Regional Office
Employee Benefits Security Administration (EBSA)
200 West Adams, Suite 1600
Chicago, IL 60606
(312) 353-0900
http://www.dol.gov/dol/topic/health-plans/cobra.htm

For more information on continuation and conversion, call the OCI at 1-800-236-8517 and request a copy of *Fact Sheet on Continuation and Conversion in Health Insurance Policies* that describes both state and federal law. A copy is also available on the OCI's Web site at http://oci.wi.gov/pub_list/pi-023.htm.

Medicare, Medigap Insurance, Medicare+Choice, and Medicaid

Medicare is the health insurance program administered by the federal Centers for Medicare & Medicaid Services (CMS) (http://www.cms.gov) for people 65 and over and for some people under 65 who are disabled. It pays many health care costs for eligible persons. A booklet entitled *Medicare and You* is available free from any Social Security office. It gives a detailed explanation of Medicare.

Medicare was designed to increase access to health care and reduce its financial burden on older, retired or disabled Americans. Although Medicare covers many health care costs, you still have to pay Medicare's coinsurance and deductibles. If you do not have adequate group insurance and are not eligible for Medicaid (described below), you may want to buy an individual Medicare supplement insurance policy, Medicare select policy, Medicare+Choice insurance policy, or a Medicare cost insurance policy.

The OCI publishes several consumer guides to assist seniors in their shopping for insurance. The publications should be used only as a guide. *Medicare Supplement Insurance Approved Policies* (http://oci.wi.gov/pub_list/pi-010.htm) lists all policies available in Wisconsin including benefits and current premiums. *Medicare+Choice - Questions and Answers* (http://oci.wi.gov/pub_list/pi-099.htm) explains new options available to Medicare-eligible persons age 65 and over, and some Medicare-eligible disabled individuals under age 65, who are looking for information about the Medicare+Choice program. *Wisconsin Guide to Health Insurance for People with Medicare* (http://oci.wi.gov/pub_list/pi-002.htm) explains Medicare and supplemental insurance to cover those expenses not paid by Medicare. Copies of the guides are also available by calling the OCI at 1-800-236-8517.

Medicaid, also known as Medical Assistance, is a government health care program paid for by state and federal governments. You may qualify for Medicaid if you are a citizen of the United States or an "eligible" person, meet the financial eligibility requirements, and are in one of the following categories:

- Age 65 or older
- Blind or disabled
- Under age 19
- Pregnant
- A caretaker of a deprived child. A deprived child is a child who has one or both parents absent from the home or has both parents in the home but one parent is incapacitated, unemployed, or an offender working without pay. The caretaker must be a relative of the child to be covered by Medicaid.

If you apply for Wisconsin Medicaid and are not eligible because your income is over the limit, you may still be able to receive Medicaid if you have high medical bills. Ask your local county Human or Social Services Department or certifying Tribal Agency (http://www.dhfs.state.wi.us/Medicaid1/contacts/medcontact1.htm) about the Medicaid deductible program.

Other Types of Special Coverage

There are several other types of policies on the market. They are not substitutes for basic or major medical coverage.

Hospital confinement indemnity. This type of policy pays a fixed amount for each day in the hospital for a specified number of days. The amount may range from $5 to $100 a day or more. Sometimes benefits are not paid until you have been hospitalized for several days. Because the average hospital stay is about seven days, these policies are often not a good buy unless the daily benefit is quite high.

Long-term care policies. Neither Medicare nor medigap insurance policies provide coverage for long-term nursing home stays. There are several types of policies on the market which cover long-term care. A *Guide to Long-Term Care* (http://oci.wi.gov/pub_list/pi-047.htm) and *Long-Term Care Policies Approved in Wisconsin* (http://www.oci.wi.gov/pub_list/pi-046.htm) are available from the Insurance Commissioner's Office by calling 800-236-8517.

Specified disease policies. These policies cover a specific disease or group of diseases. The most common type is cancer insurance. If you already have comprehensive coverage, this coverage is not necessary.

Any insurer selling cancer insurance must give the *A Shopper's Guide to Cancer Insurance* (http://oci.wi.gov/pub_list/pi-001.htm) to all applicants.

Vision and dental policies. These are policies which provide benefits only for vision or dental care. They should not be bought as substitutes for more comprehensive coverage.

Disability Income Insurance

Anyone who works probably needs disability income insurance to help replace income lost because of a long-term injury or illness. People of working age are more likely to become disabled than they are to die—making disability insurance at least as important as life insurance.

There are numerous types of disability insurance policies available. You have to be a wise consumer and look at the different products. You have to choose the product that best suits you.

Disability income policies have waiting periods before benefits become payable. The waiting period starts after you have become disabled for a covered disability. The longer the waiting period, the lower the premium will be. The period of time for which benefits are payable can also vary considerably. Benefit periods may depend on whether the disability was caused by an accident or illness. A long-term policy may provide for lifetime accident benefits and illness benefits to the age of 65. The longer the benefit period, the higher the premium will be.

What it Covers

The amount of monthly benefit provided by a disability income policy may be stated as a percentage of income or as a set dollar amount. The amount of benefit for which you can qualify is usually based on a percentage of your gross earnings, normally around 60%. A partial disability benefit may be provided, or may be available, on an optional basis.

Some policies may reduce your benefit by the amount you receive from social security or worker's compensation so your disability benefit and social security or worker's compensation benefits together will provide a specified income. Some companies will consider possible social security benefits when they decide the amount of benefits for which you qualify.

Occupational therapy and vocational rehabilitation benefits may also be provided by a disability income policy.

Things to be aware of regarding disability insurance

A disability income policy generally requires that you be totally disabled before benefits are paid. The definition of total disability varies from policy to policy. There are two different definitions used in disability policies. One definition is that you are unable to perform your own occupation. The other definition is much more comprehensive requiring that you are unable to perform any occupation (for which you are suited by education or experience). This distinction can be important for jobs that require very specialized physical skills such as surgeons or loggers.

Some points to check:

- What is the definition of disability? Does it cover both injury and sickness? Is it for partial or total disability? Is it defined as inability to perform your current occupation or as inability to perform any occupation of which you are capable?
- Does it cover both injury and sickness? Is it for partial or total disability?
- When does coverage begin? Is it different for injury and sickness?
- How long will benefits be paid? What is the weekly or monthly benefit?
- How much of your income will be replaced?
- What does it cost?
- Is it guaranteed renewable?

Disability income policies may specify that income benefits will not be paid to a disabled person if the disability results from certain causes. Check the policy for any exclusions or limitations that might apply. If you have any questions, ask your agent.

You should not assume that Social Security benefits will take care of you if you become disabled. Social Security provides long-term disability benefits based on pay and how long you have worked, but the benefits usually are smaller and administered very strictly. Just to qualify, a person must have a disability that is expected to last for at least one year or result in death.

Determining whether you need disability insurance is a personal choice. You must decide how much financial risk you are willing to assume should you suddenly find yourself unable to work for an extended period. How many months can you rely on your savings? How easy will it be for you to rebuild your nest egg for your retirement years? Can your spouse's income cover the lost salary?

Medical Underwriting

Before you can buy an individual health insurance policy you must give the insurance company information about your health. This process is called underwriting. The company uses underwriting information to predict what the likelihood is that you will file claims against the policy. Each company has its own underwriting standards, which means one company could reject your application but another may be willing to accept it.

The insurance company will get most of its underwriting information from these sources:

- Your application form
- Your past medical history
- The Medical Information Bureau (discussed on page 14)

Underwriting Decisions

Insurance companies can accept your application and issue the policy as requested or they can do one of the following:

- Issue the policy with full protection but charge a higher premium. This might occur if you have a chronic disease such as diabetes.
- Modify the benefits, such as increase the deductible.

- Exclude a specific medical problem from coverage by adding an exclusion rider.

- Decide not to issue a policy—turn down your application for insurance.

If you are turned down or denied coverage:

- Find out why you were denied coverage. The company is required to provide you with that information in writing. If it is due to your medical history, make sure the information the company received was correct.

- Try several other insurance companies or HMOs. Every company has its own underwriting guidelines. Some may view your situation differently.

- If you cannot find coverage from an insurance company, you may be eligible for benefits under the Wisconsin Health Insurance Risk-Sharing Plan (HIRSP). More information on HIRSP is provided on page 9.

The Medical Information Bureau

When you sign the application form, you authorize the insurance company to obtain information about you from the Medical Information Bureau (MIB). The MIB is a private company that insurance companies use to share information about insurance applicants. If you are denied coverage based on medical history, you may want to find out if you have an MIB file and if so, is it correct? If your file contains incorrect information, you have the right to ask the MIB to correct it. You may obtain a copy of your report by calling or writing to:

Medical Information Bureau (MIB)
P.O. Box 105
Essex Station
Boston, MA 02112
(614) 426-3660
http://www.mib.com

Consumer Tips

- Shop around. Health insurance is expensive. If you are buying individual insurance, check with several agents and companies before making a final choice.

- Using the *Health Care Coverage Worksheet* in the back of this booklet will give you a more accurate idea of what your actual policy premium will be.

- Be sure to get the Schedule of Benefits. This is a brief explanation of specific benefits and benefit limitations for covered services provided under the terms of the Certificate of Insurance.

- Buying several limited policies can be very expensive and you may not have the coverage you need.

- When you apply for coverage, fill out the application accurately and completely. If you knowingly give incorrect or misleading information or fail to disclose relevant information, your coverage could be canceled or benefits denied.

- Never sign a blank application. Verify any information filled in by the agent.

- Make payments by check or money order payable to the insurance company or HMO, not to the agent. Insist on a signed receipt on the company's letterhead. Pay no more than two months premium and fees until you have received the policy, group certificate or HMO subscriber certificate.

- Make sure you have the full name, address, and phone number for both the agent and the insurance company or HMO.

- Be careful about mail order policies and those sold door-to-door. You may need a local agent to help you with claims.

- Avoid duplicate coverage. Insurance companies often coordinate benefits so that you may collect on only one policy.

- Know your rights. For example, insurers may not:

  - Offer different benefits to men than they do to women who are in the same underwriting classification.

  - Charge different rates for men and women unless it can be justified by experience.

  - Treat persons with physical or mental impairments differently than other people unless it can be justified by experience.

Worker's Compensation Insurance

Farmers and their dependents may find themselves financially ruined if they are injured on the farm and discover that their health insurance company will not

pay the claim because the accident was work-related and should be covered by worker's compensation.

In 1911, Wisconsin adopted a Workmen's Compensation Act (Act). The intent of the law was to require an employer to promptly and accurately compensate a worker for any injury suffered on the job, regardless of the existence of any fault of whose it might be.

The Act limits the amount that a worker can recover. Workers are entitled to certain wage loss benefits; the cost of medical treatment; and certain disability payments. Recovery under worker's compensation is limited to these three areas, no matter how serious the injury.

Worker's compensation is a system of no fault insurance that pays benefits to employees for accidental injuries or diseases related to the employee's work.

Worker's compensation insurance is unique because the named insured is **not** the direct recipient of the policy benefits. Employees receive benefits that are paid by the insurer on behalf of the employer who is the named insured.

Benefits Under Worker's Compensation Insurance

Worker's compensation benefits can provide the urgently needed medical care. And, it can provide the needed financial support for farmers and their families. Basic benefits include:

1. Coverage of all reasonable and necessary medical costs.

2. Benefits for temporary wage loss [Temporary Partial Disability (TPD) or Temporary Total Disability (TTD)] sustained by an employee while recovering from injury. Eligibility for temporary disability benefits is determined and must be documented by a doctor. Benefits for temporary wage loss due to disability are based on two-thirds of the employee's wage rate up to a specified maximum amount.

3. Benefits for permanent disability [Permanent Partial Disability (PPD) or Permanent Total Disability (PTD)] if the employee does not fully recover from the injury. Permanent disability is awarded for the potential, or actual, loss of earning capacity. The amount of benefit payment for permanent disability depends on the seriousness of the permanent disability.

4. Vocational rehabilitation and retraining. For information on job retraining or placement, call or write the Worker's Compensation Division.

Temporary Disability

Eligibility for temporary disability benefits is determined and must be managed by the doctor. Benefits for temporary wage loss due to disability are based on two-thirds of the employee's wage rate up to a specified maximum amount.

Permanent Disability

When an employee-patient's condition has leveled off and the prospect for future improvement is unlikely, the doctor usually declares that a "healing plateau" has been reached. The patient is then evaluated for any residual permanent disability, generally referred to as a Permanent Partial Disability (PPD) rating. Permanent disability is awarded for the potential, or actual, loss of earning capacity. The amount of benefit payment for permanent disability depends on the seriousness of the permanent disability.

Death Benefits

Worker's compensation insurance also provides that if a work-related death occurs to an injured employee, death benefits and burial expense will be paid up to specific limits.

If you have any questions regarding worker's compensation insurance benefits paid to an injured employee, or if you have a specific complaint contact:

Wisconsin Worker's Compensation Division
Department of Workforce Development
http://www.dwd.state.wi.us

Appleton Area Office:
Worker's Compensation Division
Fidelity Bank Bldg., Rm. 310
1500 North Casaloma Drive
Appleton, WI 54913-8200
(920) 832-5450 Phone
(920) 832-5355 Fax

Madison Area Office:
Worker's Compensation Division
201 East Washington Avenue, Room 161
P.O. Box 7901
Madison, WI 53707
(608) 266-1340 Phone
(608) 267-0394 Fax

Milwaukee Area Office:
Worker's Compensation Division
State Office Building
819 North Sixth Street, Rm. 330
Milwaukee, WI 53203
(414) 227-4382 Phone
(414) 227-4012 Fax

A. Worker's Compensation and Farming In Wisconsin

Anyone engaged in farming who employs six or more persons (at one or more locations) on any 20 consecutive or nonconsecutive days during a calendar year must have worker's compensation insurance. The insurance must be in place 10 days after the 20th day of employment has been reached. A calendar year is defined as January through December. Some relatives of the farmer are not counted as employees.

There is no wage threshold for farmers. It doesn't matter how much a farmer pays in wages. What matters is the number of employees (after excluding certain employees who are family members, relatives, or "exchanged workers").

If the farm is a sole proprietorship, a partnership, or a limited liability company, relatives are defined as the parents, spouse, child, brother, sister, son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law, or sister-in-law of a farmer, are not considered to be or counted as employees of the farmer.

If the farm is a family farm corporation, all shareholders must be related as lineal ancestors or descendants. Shareholders of the family farm corporation do not count as employees of the farm. Relatives of a shareholder, as defined above, are not considered to be or counted as employees of the family farm corporation. All other employees are counted as employees.

If a farm is a corporation, where all shareholders are not related, all employees, including relatives, are considered to be and counted as employees.

For purposes of counting six or more employees, farmers or their employees working on an exchange basis are not to be counted as employees of the farmer to whom their labor is being furnished in exchange. However, these individuals may qualify for worker's compensation benefits if they sustain an injury while at work on an exchange basis and the farmer employer is already subject to the law.

Definition of Farmer - s. 102.04 (1) (c), Wis. Stat.
Definition of Farming - s. 102.04 (3), Wis. Stat.
Definition of Employee of a Farmer - s. 102.07 (5) (a) (b) (c), Wis Stat.

B. Obtaining Worker's Compensation Insurance

Private Insurance

There are about 300 insurance companies licensed to write worker's compensation insurance in Wisconsin. Contact a local agent to assist you in applying for insurance to the company of your choice.

If an insurance company turns down your application for insurance, you should ask your agent to search the marketplace for another company. A list of Licensed Worker's Compensation Insurance Companies (http://oci.wi.gov/workcomp/wcliccos.htm) and a Directory of Licensed Insurers (http://oci.wi.gov/dir_ins.htm) that includes addresses and phone numbers is available on OCI's Web site.

Wisconsin Worker's Compensation Pool

If coverage is not available in the private market, your agent may submit an application to the Wisconsin Compensation Rating Bureau (Bureau). The Bureau acts as administrator and trustee of the Wisconsin Worker's Compensation Insurance Pool. The pool is a risk-sharing plan created to provide worker's compensation insurance to any insured who is unable to obtain coverage in the private market and who is, in good faith, entitled to such insurance. Out-of-state employers with no Wisconsin operations and Wisconsin employers who owe the pool monies from prior policies are not eligible for coverage.

All insurers licensed to write worker's compensation insurance in Wisconsin must participate in the pool, and are represented by eight private insurance companies that have been designated as servicing carriers. These companies write policies in their own name and provide claims, loss control, auditing, and other services, just as they would for their voluntarily underwritten policyholders.

C. Penalty For Not Providing Coverage

The penalty for failure to carry worker's compensation insurance when required, is twice the amount of premium not paid during an uninsured time period or $750, whichever is greater. Under certain circumstances, an employer who has a lapse in worker's compensation insurance coverage can be subject to a penalty of $100 for each day they are

uninsured up to 7 days. [ss. 102.82 (2) (a) and 102.82 (2) (ag), Wis. Stat.]

In addition, an uninsured employer is personally liable for reimbursement to the Uninsured Employers Fund for benefit payments made by the Fund under s. 102.81 (1), Wis. Stat., to an injured employee (or the employee's dependents) of the uninsured employer. [s. 102.82 (1), Wis. Stat.] The penalties and reimbursements to the Fund are mandatory and non-negotiable. The usual personal exemptions of property from seizure and sale on execution of a judgment do not apply. [s. 102.28 (5), Wis. Stat.]

D. Worker's Compensation Costs

The cost of worker's compensation insurance will vary. The cost does not depend on how hazardous the job is, but rather on how many Wisconsin losses have occurred in the class of business of the employer. It is the business of the farmer that is classified and not the specific job.

There are several different kinds of jobs involved in farming, some of which are more hazardous than others. Nonetheless, all of these jobs are being performed for an employer engaged in farming, and all of the employees' payrolls would be classified in the same classification.

The Bureau sets the premium rate for each class with the approval of the Commissioner of Insurance. If you feel that your business is not properly classified or the premium charge is not proper, you can appeal to the Bureau for review of your situation. If you are still not satisfied with the Bureau's decision, you may request, in writing, that the Commissioner of Insurance hold a hearing to review the Bureau's decision.

E. Classification System For Farm Operations

The purpose of the worker's compensation classification system is to group similar employers so that each classification reflects exposures common to them. Each classification combines the payroll and losses of similar employers to develop a price.

Most of Wisconsin farming classifications fall within the 0006 and 0008 codes in the Wisconsin Compensation Rating Bureau. Code 0006 is applicable to the typical beef and dairy cattle farm operation and includes raising cash crops like wheat, corn, and so forth. Code 0008 specifies vegetable farmers who sell their products to canneries or road side stands. There is a rate per $100 annual payroll dollars and a minimum premium payment for that classification. The rate per $100 of payroll is only part of the premium calculation; an expense constant is added to the answer before it is compared to the minimum premium. Farmers under the 0006 classification are determined to be higher risk and are rated higher than the 0008 classification.

Once a farmer's standard premium is calculated the larger farmer's premium may be further adjusted by an experience rating factor that compares the farmer's past losses over a 3-year period with losses an individual farmer of that size was expected to have during the same 3-year period. If the farmer's actual losses were less than expected, credit will be given. If the farmer's actual losses were greater than expected, a surcharge will be made. Contact your insurance agent for more information on how the premium will be calculated for your individual farm operation.

Any person engaged in farming who has become subject to the Worker's Compensation Act, may withdraw by filing with the Department of Workforce Development, provided he or she has not employed 6 or more employees on 20 or more days during the current or previous calendar year. A farmer may again become subject to this Act by employing 6 or more employees on 20 different days during a calendar year. (Election of Coverage by Farmer Withdrawal - s. 102.05 (3), Wis. Stat.)

For more information on the Wisconsin Worker's Compensation Insurance Pool or if you have a complaint involving classification or rates contact:

Street Address
Wisconsin Compensation Rating Bureau
20700 Swenson Drive, Suite 100
Waukesha, WI 53186

Mailing Address
Wisconsin Compensation Rating Bureau
P.O. Box 3080
Milwaukee, WI 53201-3080

Phone Number
(262) 796-4540

Internet Address
http://www.wcrb.org

F. Frequently Asked Questions

Who is a farmer?

The statutory definitions of farming, farm premises, farm operations and farmers are extremely broad. The law has a long list of farm operations related to plant

and animal commodities that cover everything from cultivating, breeding, tending, raising, training, managing and harvesting to processing, drying, packing, packaging, freezing, grading, storing, delivering, distributing, or marketing. The law also says that farming shall also include "any other activities commonly considered to be farming whether conducted on or off (farm) premises."

What if I rent?

It makes no difference whether the farmer owns or rents the farm premises. The same broad exemptions from the requirement to obtain insurance apply.

What if I don't make a profit?

It does not matter. There is no requirement that the farmer actually succeed in raising any crop, animal, animal product, or commodity.

What about logging?

"Logging, lumbering or wood cutting" operations are not, by themselves considered farm operations. However, if they are done as part of other farm operations, they are considered farm operations for all worker's compensation purposes. On the other hand, clearing farm premises, salvaging dead timber and managing and using wood lots are, by themselves, considered farming. They are not considered "logging, lumbering or wood cutting."

What about people who provide services to farmers?

Commercial threshers, clover hullers, silo fillers, corn shredders, and other employers who work for farmers are not considered to be engaged in farming operations. These contractors become subject to the Worker's Compensation Act like any other non-farm employer. These employers and their employees are not counted for purposes of determining whether a farmer has 6 employees.

I recently was required to get a worker's compensation policy for my farm operation. Can I exclude my relatives from coverage under the policy?

No, relatives cannot be excluded from coverage. The policy covers all employees including your relatives. Insurance premiums will be charged on all of your employees wages including any relatives that work for you. Only two corporate officers of a closely held corporation and members of a qualified religious sect who are certified for exemption by the Department of Workforce Development may be excluded from coverage. All other employees are covered. (Contact the Worker's Compensation Division to request the religious sect exemption forms and related informational materials.)

Can a farmer voluntarily obtain worker's compensation insurance?

Yes, all employers, including farmers, may voluntarily elect coverage for themselves or their employees. In the event of a work-injury, they are eligible for all medical, wage and other worker's compensation benefits, without regard to who was at fault in causing the injury. The voluntary purchase of a worker's compensation policy also protects the employer from most civil tort actions by employees related to the work-injury. With few exceptions, where the employer has the worker's compensation insurance coverage in place, an injured worker is limited to the benefits to which he or she is legally entitled under the Worker's Compensation Act.

I thought I was subject to the Act, so I took out a policy. Now, I find out I was never required to have coverage. What can I do?

Whenever anyone voluntarily elects coverage, whether purposely or by mistake—and assuming that during the period for which voluntary coverage is obtained the farmer does not otherwise become subject to the Act by having 6 or more employees on 20 days during a calendar year—the person may cancel that policy at any time. There is no waiting period.

My neighbor and I are farmers who, together with our crews, often work together on an exchange basis on each other's farms. Do I count my neighbor's employees as my employees when they are working on my farm?

A special law applies to farmers who exchange workers. For purposes of counting, your neighbor and his or her employees are not counted toward your 6-employee threshold. Your neighbor's employees are counted only by your neighbor to determine whether he or she has 6 employees on 20 days and is subject to the Act.

Once a farmer is required to get insurance, how long does he or she have to keep it?

Quite a while. Once a farmer is required to obtain insurance, even if he or she permanently drops below 6 employees, the farmer must maintain the insurance for the remainder of that calendar year—and for the

next calendar year—before he or she is eligible to withdraw.

Once a farmer has gone a full calendar year without employing 6 or more employees on 20 days, the farmer may drop insurance coverage by first filing a notice of withdrawal with the Worker's Compensation Division, and then waiting 30 days. The coverage will automatically lapse. If, for some reason, the farmer wants to drop coverage more than 30 days later, the later date should be specified in the notice of withdrawal. Farmers should contact the Worker's Compensation Division for the necessary withdrawal forms.

Farmers who are not subject to the law and do not carry worker's compensation insurance may be sued in a civil action for damages by an employee who is injured while at work.

Health Insurance Coverage for Farm Accidents

Worker's compensation is highly recommended even for farmers who are not required to provide it by law. If you don't have worker's compensation for all family members who help with farm work, it is important to understand the policy of the insurer about coverage for on-farm injuries and farm-related illnesses. You CANNOT assume that your health insurance will cover all farm accidents. Most health insurance policies exclude "treatment, services and supplies for any injury or illness covered by worker's compensation." Some policies may also exclude such treatment for any person who is ELIGIBLE FOR OR COVERED BY worker's compensation. This includes any award or settlement you may receive for any disease or injury eligible for coverage. It also means the insurer may not cover an injury or disease that would be covered under worker's compensation but is not as you did not elect to sign up even though you were eligible.

Ask questions and get written statements about coverage for all family members who may be helping with farm work. Although farm plans which are marketed only to farm families are more likely to cover farm-related illness or injuries, it is important to read the exclusions and clarify the benefits if you don't have worker's compensation.

> It is extremely important to read a health insurance policy very carefully when "shopping around" for insurance, in order to avoid these exclusions when worker's compensation is not purchased in addition to the health insurance policy.

Insurance Marketing

For the most part, insurance is sold directly through a company or through an agent. Companies that sell directly maintain their own staff of agents or sell policies through the mail. An independent agent is not employed by any insurance company and usually represents several different companies.

When you first talk to an agent, be sure that he or she is willing and able to explain various policies and other insurance-related matters. An agent should look for ways to get you the most protection at an affordable cost. Make certain that your agent agrees to review your coverage from time to time, advises you about other financial services, and assists you when problems develop.

Many people are interested in selling package products or services to as many people as possible. While there is nothing wrong with low cost, standardized products, they should fit your needs. If you are not convinced that a particular agent understands your needs and will give you the service you want, seek another agent.

Agents and companies differ. Check with friends and relatives for recommendations. Agents and companies are listed alphabetically and by location in the yellow pages of the telephone book.

All companies and agents doing business in Wisconsin are licensed by the Insurance Commissioner's Office. To find out if a company is licensed call (608) 267-9456. For agents call (608) 266-8699 or 1-800-236-8517 (outside Madison).

Terminations, Denials, and Cancellations

New Policies

When a policy first becomes effective, the insurer may cancel that policy any time within the first 60 days without providing you with a reason for the cancellation. The cancellation is not effective until at least ten days after the insurance company mails or delivers to you a written notice of cancellation.

Renewal on Altered Terms

Sometimes an insurer will renew a policy but will raise the rates or make the terms less favorable to the insured. An insurer may not alter the terms of coverage until 60 days after a notice is mailed to you. To be effective, the notice must be mailed or delivered prior to the renewal date. If the notice is given less than

60 days before the renewal date, the new terms or premium increase will not become effective until 60 days have elapsed from the date the notice is given. These conditions do not apply if the only change is a rate increase of less than 25%.

Renewal of Health Policies

All fully insured comprehensive group and individual health insurance policies are guaranteed renewable under HIPAA as long as premiums are paid on time and there is no evidence of fraud. This does not extend to limited benefit plans such as LSHOs, hospital indemnity or single disease plans. However, these health policies may be automatically renewed. Guaranteed renewable health policies permit the policyholder to continue for a stated period as long as the premiums are paid. HMOs and LSHOs may also require the policyholder to continue to reside in the service area. Insurers may raise premiums on these policies. Noncancellable policies are guaranteed renewable for a stated period at a guaranteed premium. An optionally renewable policy is one under which the insurer retains some right to refuse renewal. Premiums may be raised. Some health policies are not renewable.

Nonrenewals

If an insurer decides it does not want to renew your policy, it must mail or deliver to you a nonrenewal notice at least 60 days before the policy's expiration date. The nonrenewal notice must include the specific reasons for nonrenewal.

If an insurer fails to provide notice prior to the expiration date, it must continue your coverage under the terms and premium of your prior policy for the term of the policy or one year, whichever is less.

If you are nonrenewed solely because of the termination of your agent's contract with your insurer, the insurer must continue your coverage if you request the insurer to do so in writing prior to the expiration date and you meet the insurer's eligibility requirements.

Midterm Cancellations

A midterm cancellation is a cancellation that occurs during the policy term and prior to the policy's expiration or renewal date. An insurance company may cancel coverage during this period only if the premium is not paid or if the policy states other reasons for canceling. The insurer must either mail or deliver to you a written cancellation notice. No cancellation is effective until at least ten days after the mailing or delivery of the notice.

Grace Period

Although an insurer may cancel your policy for nonpayment of premium, you may be entitled to a grace period. This is the period during which coverage continues even if the premium has not been paid. For health insurance it is seven days for weekly premium policies, ten days for monthly premium policies, and one month for all other policies. No grace period is required for auto or property insurance.

Anniversary Cancellations

This refers to a policy written for an indefinite term or for more than one year. These policies may be canceled on any anniversary date if the policies contain cancellation provisions. If your insurer decides to cancel your policy on an anniversary date, it must mail or deliver to you a written notice at least 60 days prior to the anniversary date.

General Anti-Discrimination Laws

There are statutes and rules that protect consumers from unfair discrimination in insurance policies.

Insurers may not refuse to insure you or refuse to renew your policy on the basis of sex.

For auto or homeowner's policies, insurers may not refuse coverage to a class of risks solely on the basis of past criminal record, physical disability, past mental disability, age, marital status, sexual preference, "moral" character, or the location or age of the risk. Insurers may not use these classifications to charge different rates without credible supporting information.

No insurer may cancel or refuse to issue or renew an automobile insurance policy wholly or partially because of one or more of the following characteristics of any person: age, sex, residence, race, color, creed, religion, national origin, ancestry, marital status, or occupation. Some of the classifications may be used by an insurer if its experience supports differences in losses from these classifications.

For Your Protection

Information is available to consumers from a number of sources. These sources include public libraries, state insurance departments, consumer groups, and consumer publications. Financial strength and being able to meet financial obligations to policyholders is very important.

Independent organizations such as A.M. Best, Standard & Poors, Moody's Investors Service, and others publish financial ratings. These rating organizations do not rate the quality of the company's policies, practices, agents, or service. You should consider checking with at least two organizations to evaluate a company's strength. If you want to check on an insurance company's financial stability, you can check the reference section of your public library for published ratings, call the Insurance Commissioner's Office, or check with your agent.

Every state has a safety net to protect insurance consumers from financial loss in the rare instance that a company becomes insolvent. This safety net is called a "guaranty fund." The guaranty funds are established by state law and are composed of licensed companies in the state. They pay the claims of policyholders and other claimants of an insolvent company. The money to pay the claims against the insurance company comes from assessments made against all of the insurance companies that are members of the guaranty fund.

In Wisconsin, this fund is called the Insurance Security Fund (Fund). The Fund is created by state law and is funded by assessments of insurers licensed to do business in Wisconsin. In general, the Fund protects residents for most claims of licensed insurers in liquidation. The Fund should not be relied upon to eliminate all risks of loss to insureds due to insurer insolvency. Some types of policies may not be fully covered and significant delays could occur in settling obligations in cases of liquidation.

Questions about the coverage and limitations of the Fund can be addressed to:

Wisconsin Insurance Security Fund
2445 Darwin Rd. #101
Madison, WI 53704
(608) 242-9472

Where to Go For Help

The Insurance Commissioner's Office does not have the authority to force a company to insure anyone. However, the office can take action against agents or insurers who misrepresent coverage, unfairly discriminate, or violate other insurance laws.

If you are having a problem with your insurance, you should first check with your agent or with the company that sold you the policy. If you do not get satisfactory answers from the agent or company, contact the Insurance Commissioner's Office. A complaint form (http://oci.wi.gov/com_form.htm) is included in the back of this booklet. Make sure you have included detailed information about your insurance problem. The more complete and accurate this information is, the more likely it is that your problem can be resolved. Be sure that you have included the correct name of the insurance company from which you bought the policy. Many companies have very similar names. Listing the wrong name may delay the investigation of your complaint.

The Insurance Commissioner's Office investigates complaints to determine if any insurance laws have been violated. If so, the office may take action against the agent or company involved. These actions include imposing fines or suspending or revoking licenses.

The Insurance Commissioner's Office publishes complaint summaries each year listing those companies that have received the most complaints. This is one way consumers have of judging the service given by insurance companies. For more information, call the Insurance Commissioner's Office at (608) 266-0103 or 1-800-236-8517 and request a copy of *Insurance Complaints and Administrative Actions* (http://oci.wi.gov/pub_list/pi-030.htm).

Small Employer Web Site

The Office of the Commissioner of Insurance (OCI) developed a Web site to help small employers become more knowledgeable insurance consumers. The Insurance Coverage for Small Employers Web page http://oci.wi.gov/smempins.htm assists Wisconsin small employers by providing information on the different types of insurance policies on the market, how much coverage to buy, and how to buy it wisely.

Health Care Coverage Worksheet

This chart may be used to compare policies. This comparison is not intended to be a complete analysis of the plan's benefits. The master contract provides a detailed description of the policy benefits. Please check your own policy for variations and further details.

Plan Name					
Premium	monthly annual				
Annual Deductible	single family				
Annual Out-of-Pocket Limit					
Coinsurance Percentage					
Preventive Care • Immunizations					
• Adult Routine Medical Exams					
• Well Child Examinations					
• Mammograms					
Hospital Services* • Room & Board, Misc. Hospital Expenses, & Intensive					
Care Unit					
• Outpatient Facility Fees					
• Outpatient Radiology, Pathology, and Lab Services					
Emergency Services • Emergency Room Care (including Physician Charges and Misc. Expenses)					
• Emergency Room Facility Fees					
• Ambulance					
Professional Services • Office Visits					
• Chiropractic Visits					
• Maternity Services					
• Medical Supplies, and Durable Medical Equipment					
• Occupational, Physical, & Speech Therapy					
• Oral Surgery and Dental Repair (due to an injury)					

* Some services may require precertification or prior approval. Financial penalties could apply if an approved precertification or prior approval is not in place for services received.

Professional Services (continued) • Independent Anesthesiologist, Pathologist, and Radiologist Services				
• X-Ray and Lab Services				
Home Health Care • Home Health Service				
Health Care Services • Breast Reconstruction (following a covered mastectomy)				
• Diabetic Equipment, Supplies, and Self-Management Education Programs				
• Temporomandibular Joint (TMJ) Disorders				
• Skilled Nursing Care				
Transplants (prior approval may be required) • Heart				
• Heart/Lung				
• Cornea				
• Bone Marrow				
• Liver				
• Pancreas				
• Kidney				
Alcoholism, Drug Abuse, and Nervous or Mental Disorders • Inpatient				
• Outpatient				
• Transitional				
Prescription Drug Coverage				
Out of Area Coverage				
Additional Benefits • Preventive Dental Care				
• Vision Exams				
• Hearing Exams				
• Other				
Exclusions**				

** The Exclusions section lists the services, treatments, equipment or supplies that are excluded (meaning no benefits are payable under the Plan Benefits), or have some limitations on the benefit provided. Some of the listed exclusions may be medically necessary, but still are not covered under the plan, while others may be examples of services which are not medically necessary or not medical in nature, as determined by the Plan.

Worker's Compensation Questions? Here's Whom To Call

Worker's Compensation Division of the Department of Workforce Development (DWD) (http://www.dwd.state.wi.us)

P. O. Box 7901
Madison, WI 53707
(608) 266-1340 (Phone)
(608) 267-0394 (Fax)

- All Questions Relating to the WI Worker's Compensation Act
- All Injury/Claim Questions
- Compliance Questions
- Corporate Officer Options Questions
- Enforcement Questions
- Penalty and Penalty Payment Plan Questions
- Self Insurance Questions
- Divided Insurance Questions
- Wrap-up Policy Questions
- Withdrawal Questions

Wisconsin Compensation Rating Bureau (WCRB) (http://www.wcrb.org)

P. O. Box 3080
Milwaukee, WI 53201-3080
(262) 796-4540 (Phone)
(262) 796-4400 (Fax)

- Wisconsin Worker's Compensation Insurance Pool Questions
- Rate Questions
- Inspection Questions
- Audit Questions
- Premium Charging Questions
- Classification Questions
- Experience Modification Questions
- All Questions Regarding the Proper Filing of Policies and Endorsements Pertaining to Wisconsin Coverage
- Insurance Company Filing Questions
- Endorsement Filing Questions
- Questions Regarding Appeal Rights Of A WCRB Decision
- Questions about Statistical Reporting

Office of the Commissioner of Insurance (OCI) (http://oci.wi.gov)

P. O. Box 7873
Madison, WI 53707
1-800-236-8517 or (608) 266-0103 (Phone)
(608) 264-8115 (Fax)

- All Questions Relating to the Insurance Laws
- Questions Related to the Licensing & Regulation of Insurance Companies
- Unfair Claim Settlement Practices Questions
- Unfair Marketing Practices Questions
- Worker's Compensation Rate Regulation Questions
- Worker's Compensation Dividend Plans Questions
- Questions Related to the Licensing & Regulation of WCRB